FEDERAL PATIENT CENTERED MEDICAL HOME (PCMH) COLLABORATIVE
Catalogue of Federal PCMH Activities ***as of March 2011***

OPERATING DIVISION/DEPARTMENT:
Department of Veterans Affairs (VA)

Respondents:

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PRÉCIS:
The VA is a leader in development and implementation of the PCMH. It has funded a significant number of pilot projects, training programs, and system improvements that promote a medical home model of care. The Department sees the PCMH as central to its mission to deliver direct care to veterans, and as such, has partnered with several agencies and regularly shares its experiences interested stakeholders.

STRATEGIC GOALS OF THE OPERATING DIVISION/DEPARTMENT:

- *Strategic goals explicitly support advancing the PCMH.* The VA has developed agency-wide strategic goals and operational concepts that support movement towards a patient-centered model of care. The Secretary has developed a series of strategic goals called the "Transformation 21 (T-21) Initiatives," and the medical home is supported by the "New Models of Care" initiative. The VA has also developed a version of the patient-centered medical home called Patient Aligned Care Teams (PACT). The VA's vision is that primary care in their facilities is accessible, patient-centered, coordinated, and team-based. PACT encompasses these values, which are all part of the PCMH concept. The VA has funded a variety of demonstrations, and training and research programs, which demonstrates its commitment to advancing the PCMH model within its system.

PRIMARY AREAS OF PCMH ACTIVITY:

Direct provision of health care services or funding of care

- *Payment model reform for the Veteran's Health Administration.* Primary care is foundational care in the Veteran's Health Administration (VHA). The VHA budget is set by Congress and funds are allocated through a capitated payment model. The payment model, called Veterans Equitable Resource Allocation (VERA), is based on a Resource Value Unit (RVU) system that accounts for workload, complexity, and diagnoses of each service. Veteran Integrated Service Networks (VISNs), the VA's networks of medical centers, vet centers, and outpatient clinics offering primary and specialized care, are funded to provide patient care based in large part on this model. To date, this payment model has been focused on highly complex patients, inpatient care, etc. which does not necessarily support the medical home model that the VA will use to provide primary care. The VA has made recommendations for ways to certify their facilities as medical

homes so that they can receive improved funding to sustain the staffing level required to deliver a high quality medical home model of care. For example, it has recommended that the VERA calculation maximize the workload credit for care that is not face-to-face, which would provide patients greater opportunities to use telemedicine and access primary care services without travelling to see a provider. The revised allocation methodology will allow sites with PCMH practices to receive enhanced funding. This methodology is not unlike what the private sector is trying to address in funding medical homes.

Pilot or demonstration programs

- *Demonstration Labs.* The VA has created five demonstration labs and a coordinating center to coordinate the labs' activities. The goal of the demonstration labs is to develop evidence that will guide PCMH implementation throughout the VA in real time. The demonstration lab projects will use robust research and program evaluation methodologies to evaluate specific topics related to the medical home, such as serving rural patients, using telemedicine and secure messaging, or structuring the care team. Initial results are expected to be released within the year. Each lab works with the coordinating center to identify trends and system improvements. There are labs in each of the following five locations: 1) Los Angeles/San Diego/Loma Linda, CA; 2) Portland, OR; 3) Iowa City, IA/Minneapolis, MN; 4) Ann Arbor, MI; and 5) Philadelphia, PA. The coordinating center is located in Seattle, WA. The demo labs are grant funded and will receive $1 million a year for the next several years. The award was issued earlier this year and does not include dissemination support.
- *Centers of Excellence.* Another area of focus for VA is building and testing models for training students in patient centered medical home practices. The Office of Academic Affiliations has established five "Academic Centers of Excellence" for primary care education. These sites will work with academic affiliate organizations in their area to develop training and practice models that promote the concepts of patient medical homes, including how to design residency programs, how to allocate staff in PCMH and team based care, etc. They will award grants to academic medical centers to build models of training for staff and evaluate the effectiveness of each program. The selected sites are Seattle, Boise, San Francisco, Cleveland, and Connecticut. Working with academic medical centers has two benefits for the VA. First, it allows the VA to train medical providers in the PCMH model of care and encourages providers to promulgate the model in their community. Second, it is a recruitment tool that enables providers trained in a medical home model of care to gain exposure to and interest in working in the VA setting.

Technical assistance, implementation assistance

- *Increased staffing at primary care sites.* When the VA was initially exploring a PCMH model of care, it learned that many of the primary care sites weren't adequately staffed for team-based care. Sites had a recommended staffing ratio of 2.5:1, which included one full time primary care provider FTE to every 2.5 support staff. The VA recommended that PCMH and team-based care be delivered with an increased staffing ratio of 3:1.

That is, for every provider, there should be one clerk, one LPN/medical assistant, and one RN. The VA refers to this group as a "teamlet," and each teamlet is assigned to one panel of patients. The other members of the PCMH team, such as clinical pharmacists, social workers, and dietitians will be assigned to more than one panel, bringing the team total to 5-6 people. In addition, each facility will staff one full time worker to implement secure messaging, that is, a system for providing electronic communications between patients and providers that keeps private information protected. The VA has piloted secure messaging in 10 facilities so far and has an aggressive plan to roll out secure messaging in every facility and in every practice. The VA believes that infrastructure is very important and has focused most of its funding towards hiring and training the additional recommended staff at each primary care site; centers have begun to hire and slowly increase staffing levels.

- *PACT Compass and quality measurement.* The VA has created a PACT Compass to combine the myriad care quality measures already in use into a one-stop shopping experience in which a user can easily evaluate the patient centered medical home. The PACT Compass includes measures for panel size, capacity, and staffing; patient and employee satisfaction scores; care continuity; access; admissions; communication following discharge; specialty referral rates; and clinical indicators, like Healthcare Effectiveness Data and Information Set (HEDIS) measures. The Demonstration Labs may also use existing Compass measures to track their progress, and develop their own measures to evaluate components of care. The first phase of the Compass was rolled out in July 2010.
- *PACT Learning Collaborative.* The VA has developed a plan to train and educate providers to work as a team. The VA kicked-off its educational plan in April of 2010, and 3,600 people came together for 90 presentations on topics related to the medical home. Next, the five regional learning networks are each sending a total of 300 primary care teams to participate in six collaborative and experiential learning sessions alternating with action periods which will run through the end of FY2011. In the Collaborative, the clinical staff work together to redesign their systems. Learning Session 1 focused on access to care, and Session 2 will focus on care coordination and management. Each session is 3 days long, and after the session, participants are charged with sharing their knowledge and techniques with teams at their home facilities.
- *Transformation Initiative Learning Centers.* The VA's Transformation Initiative Learning Centers provide flexible opportunities for teams to come to a regional facility where VA faculty will provide 3-4 day training on patient-centered care, care management, coordination of care, motivational interviewing, and other topics important for staff in a PCMH setting. The VA is currently developing a standard curriculum for training faculty who will work in regions to provide training across the country. The first session begins in September 2010 and runs through the end of FY 2011. After the first session is completed, the VA will train 1,000 teams each year. The Transitional Initiative Learning Centers are different from the PACT Learning Collaborative sessions in that participants who come to the centers receive intensive training for a week but do not receive ongoing training, coaching, and support or actively share experiences.

- *Consultation teams.* The VA has created five teams of one provider (MD, PNP, or PA), one nurse, and one administrator to be deployed for facilities that are having problems or request additional help and guidance on implementing the medical home. The consultation team will work onsite with the requesting facility. The VA is currently working out a process for sites to request the teams, and they have been in the field since December 2010. The teams will be available for consultation at least through FY2013**.**
- *Mini-residency in specialty care for primary care providers.* The VA has created mini-residency programs for primary care providers to rotate through selected specialty clinics to become familiar with specialty care services and create linkages between primary and specialty care.
- *Telemedicine.* The VA is emphasizing telemedicine as a way to reduce the travel barriers that would inhibit access to care. My HealtheVet, VA's patient portal, is introducing secure messaging that enables patients to communicate with their health care team, eliminating the needs for phone calls and visits. The system will also let them view appointments, lab results, and access health records. In addition, providers can conduct electronic consults for visits that do not require face to face contact. The VA is piloting programs similar to the Project Echo videoconferencing initiative in New Mexico at several sites across the country.
- *Computerized Patient Record System (CPRS) enhancements:* The VA is enhancing its existing Computerized Patient Record System (CPRS) by reconfiguring the data collection templates. It will also begin using health record data to identify patients at high risk for admission and target prevention strategies to patient needs. A Health Risk Assessment tool, to be completed by the Veteran, is also being developed to provide comprehensive health recommendations to both patient and provider.

Research (includes evaluation)

- *Demonstration Labs.* The Demonstration Labs are involved in evaluation and are described under "Pilots and Demonstrations."
- *Centers for Excellence.* The Centers for Excellence are involved in evaluation and are described under "Pilots and Demonstrations."

MATERIALS:

Policies and Guidelines

- *Internal Materials.* There are a variety of plans and materials that have been developed for internal use. The VA is currently working to implement the plans and prepare materials for sharing with external stakeholders.

ACTIVE PCMH COLLABORATIONS WITH FEDERAL PARTNERS:

- *Department of Defense.* VA and DOD have a natural shared mission to provide health care for veterans. They also have a similar structure for care delivery and budgeting, which creates a natural partnership. The two departments have been working together

to smooth the transition from active duty to veteran care. One new initiative looks at existing architectural plans and building space recommendations for new facilities and recommends design changes needed to accommodate expanded PCMH teams.

OTHER PCMH COLLABORATIONS:

- *Patient Centered Primary Care Collaborative (PCPCC).* The VA has been involved with the PCPCC for several years. They have shared their work, met stakeholders, and learned from the work of others involved in PCMH implementation.
- *American College of Physicians (ACP).* The VA uses ACP's medical home builder to evaluate readiness as they began their transition a PCMH model.